



State of Health in the EU Slovenia

Country Health Profile 2017

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
<http://dx.doi.org/10.1787/888933593817>

Demographic and socioeconomic context in Slovenia, 2015

		Slovenia	EU
Demographic factors	Population size (thousands)	2 064	509 394
	Share of population over age 65 (%)	17.9	18.9
	Fertility rate ¹	1.6	1.6
Socioeconomic factors	GDP per capita (EUR PPP ²)	23 900	28 900
	Relative poverty rate ³ (%)	8.4	10.8
	Unemployment rate (%)	9.0	9.4

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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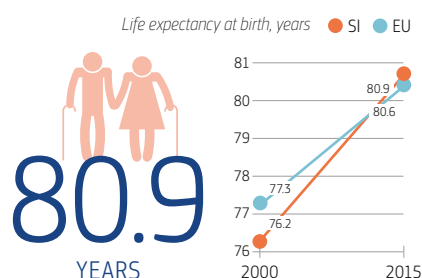
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1 Highlights

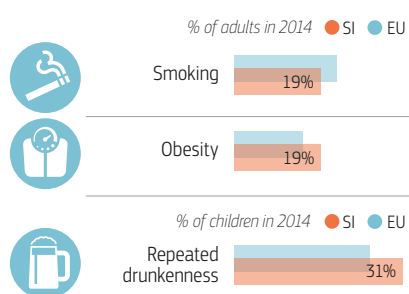
Slovenia's average life expectancy is above that of the EU and experienced one of its largest gains over the last two decades. The compulsory health insurance system is characterised by low public funding, with a significant role played by complementary health insurance. Fiscal consolidation measures in light of the economic crisis have speeded up the reform efforts to broaden the revenue base and ensure fiscal sustainability.

Health status



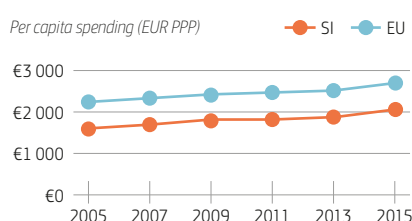
Life expectancy at birth was 80.9 years in 2015, almost 5 years longer than in 2000. However, the extra years of life are not always spent in good health and healthy life years are below the EU average. Life expectancy gains are mainly the result of a consistent reduction in premature deaths from cardiovascular diseases and cancer although these continue to be the leading causes of death.

Risk factors



In 2014, 19% of adults in Slovenia smoked tobacco every day, which is slightly below the EU average and down from 24% in 2001. Obesity rates, however, are above the EU average and for adults have increased from 16% in 2007 to 19% in 2014. Repeated drunkenness among 15-year-olds is higher than in most EU countries, but binge drinking among adults is close to EU average.

Health system

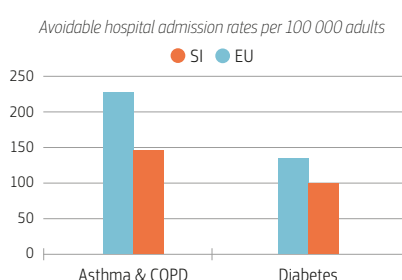


In 2015, Slovenia spent EUR 2 039 per head on health care, compared to the EU average of EUR 2 797. This equals 8.5% of GDP, which is also below the EU average of 9.9%. However, its health system is one of the most expensive among the newer Member States. Only 71.1% of health spending is publicly funded compared to 78.7% at EU level. While 13% of health expenditure is paid out of pocket the role of voluntary health insurance is significant, at 14%.

Health system performance

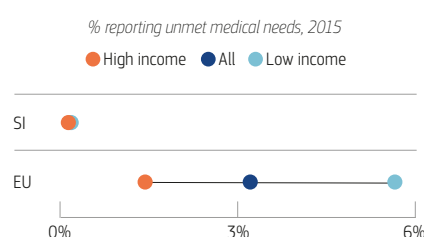
Effectiveness

Avoidable hospital admissions for ambulatory-care sensitive conditions suggest that the health system provides effective care to these patients outside of hospitals.



Access

Access to health services is good, with very low numbers reporting unmet needs for medical care and almost no variation between income groups. However, waiting lists for specialised care remain a challenge.



Resilience

The economic crisis revealed issues with the fiscal sustainability of the health system and made diversification of health revenues a priority. There is also room to improve efficiency in relation to hospital care, provider payment and procurement systems.



2 Health in Slovenia

Life expectancy has increased rapidly, and recently surpassed the EU average

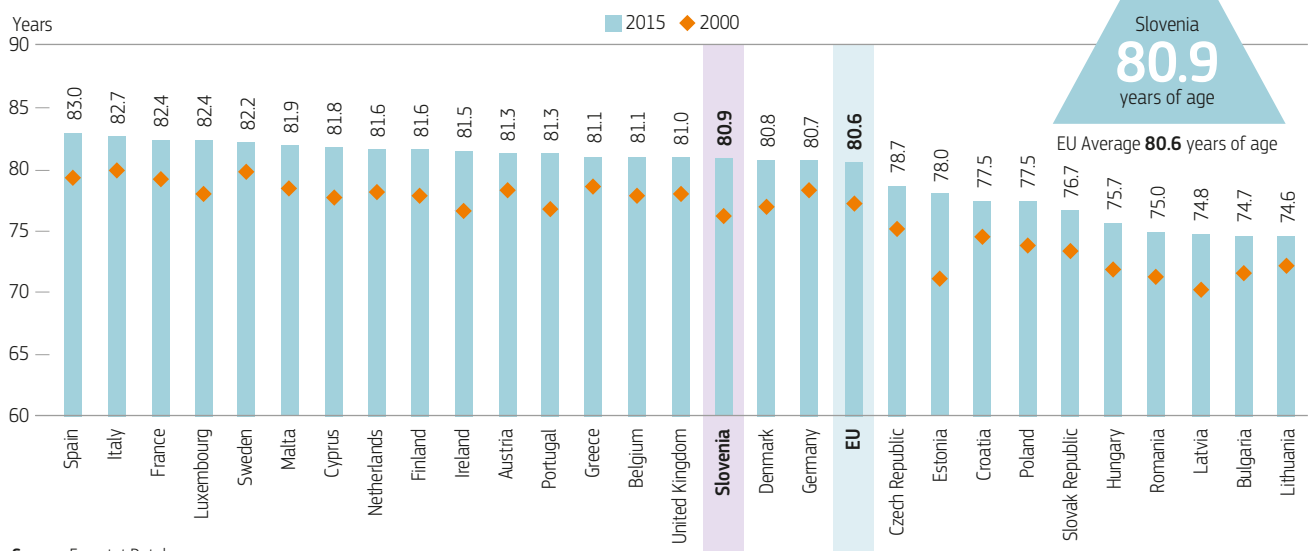
Life expectancy at birth in Slovenia has increased rapidly since 2000 (by 4.7 years), and at 80.9 years it is now slightly higher than the EU average (Figure 1). Nonetheless, there continues to be a considerable gender gap with life expectancy at birth for women exceeding that of men by more than six years and inequalities across socioeconomic groups and between western and eastern Slovenia. Slovenian men with a university education, for example, have a life expectancy at birth nearly seven years higher than those with no more than a lower secondary education.¹

Most gains in life expectancy since 2000 have been after the age of 65, with the life expectancy of Slovenian women at age 65 reaching 21.4 years in 2015 and that of men reaching 17.6 years. However, Slovenian women at 65 can expect to live only about one third (36%) of their remaining years free of disability, and men nearly half (47%).²

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

Figure 1. Great gains have been made in life expectancy in Slovenia since 2000



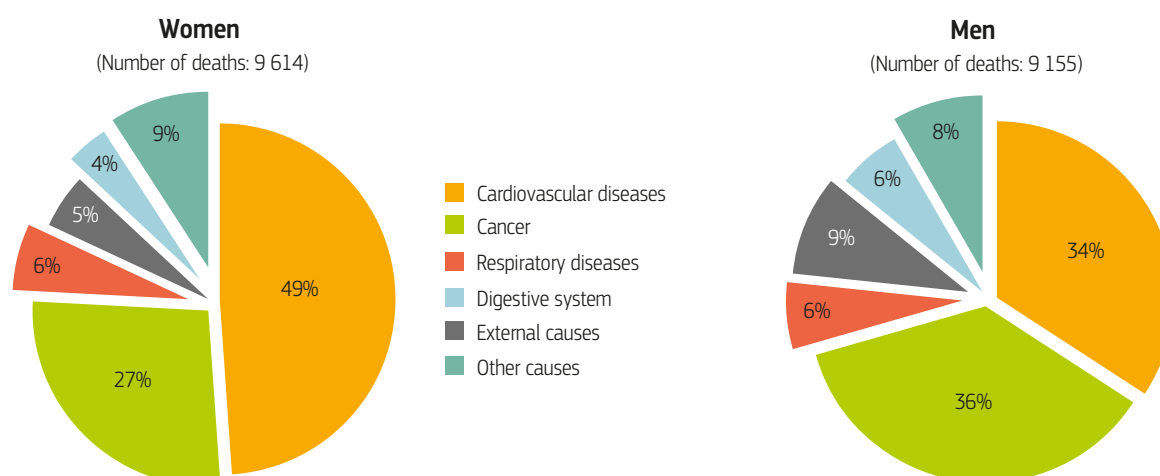
Source: Eurostat Database.

Cardiovascular diseases and cancer remain leading causes of mortality

More than three quarters of women's deaths and two thirds of men's deaths are attributable to either cardiovascular diseases or cancer (Figure 2). Although mortality rates from both cancer and cardiovascular diseases have fallen since 2000 (contributing to better life expectancy), they remain above the EU average, and for men they are actually among the worst in Europe. External causes represent the third largest group of deaths for men and rank fifth for women, mainly because of the high numbers of falls, mostly in old age, in both groups and suicides. In 2014, Slovenia ranked fourth in terms of mortality from suicide in the EU, with particularly high levels among men and large regional disparities between western and eastern Slovenia – with eastern Slovenia doing worst, as it does on a number of economic and educational indicators.

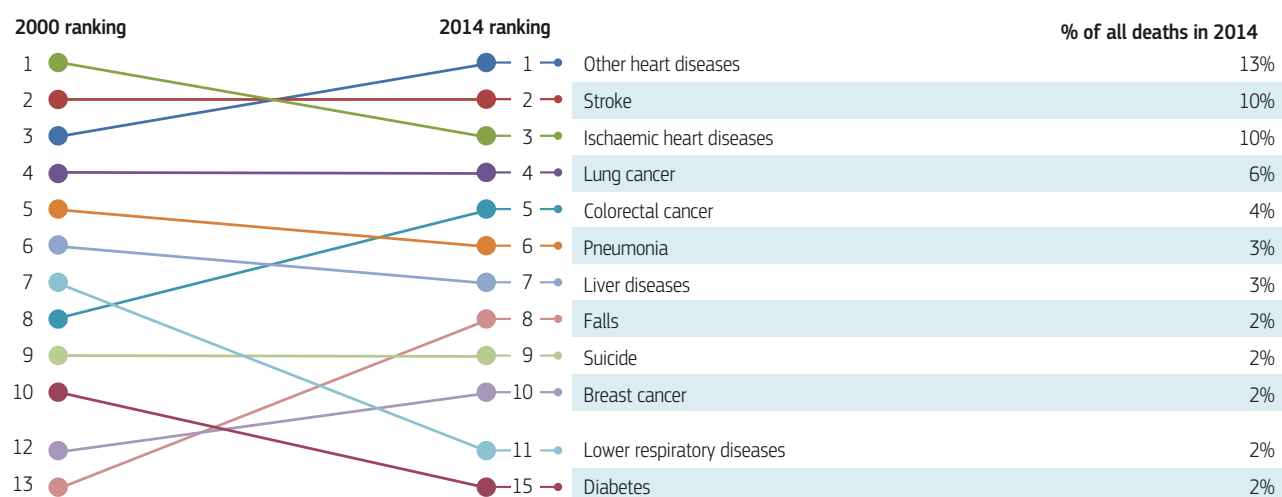
The leading causes of death have remained the same but their relative positions have changed

Looking at more specific causes of death, stroke and heart diseases remain the main causes of death in 2014, followed by mortality from lung cancer (Figure 3). Between 2007 and 2013 lung cancer mortality rates decreased overall, although their ranking was unchanged. This decrease was very large for men and is a legacy of declining smoking rates from the early 2000s (see Section 3). However, death rates for women continue to increase (and contributed to an upward trend in death rates seen in 2014), although again, this reflects more on past patterns of behaviour than on health care effectiveness.

Figure 2. Cardiovascular disease and cancer are leading causes of death

Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Heart diseases and stroke remain the main causes of mortality

Source: Eurostat Database.

Back pain, depression and dementia are leading contributors to poor health

Musculoskeletal problems (including low back and neck pain), mental health problems (including depression and suicide) and Alzheimer's disease and other dementias also contribute to disability-adjusted life years³ (DALYs) in Slovenia (IHME, 2016).

Based on self-reported data from the European Health Interview Survey (EHIS), nearly a quarter of people in Slovenia live with hypertension, 1 in 11 live with chronic depression, 1 in 20 with asthma, and 1 in 14 with diabetes. There are marked socioeconomic disparities and people with the lowest level of education are more than two and a half times as likely to live with diabetes and almost 40% more likely to live with asthma as those with the highest level of education.⁴

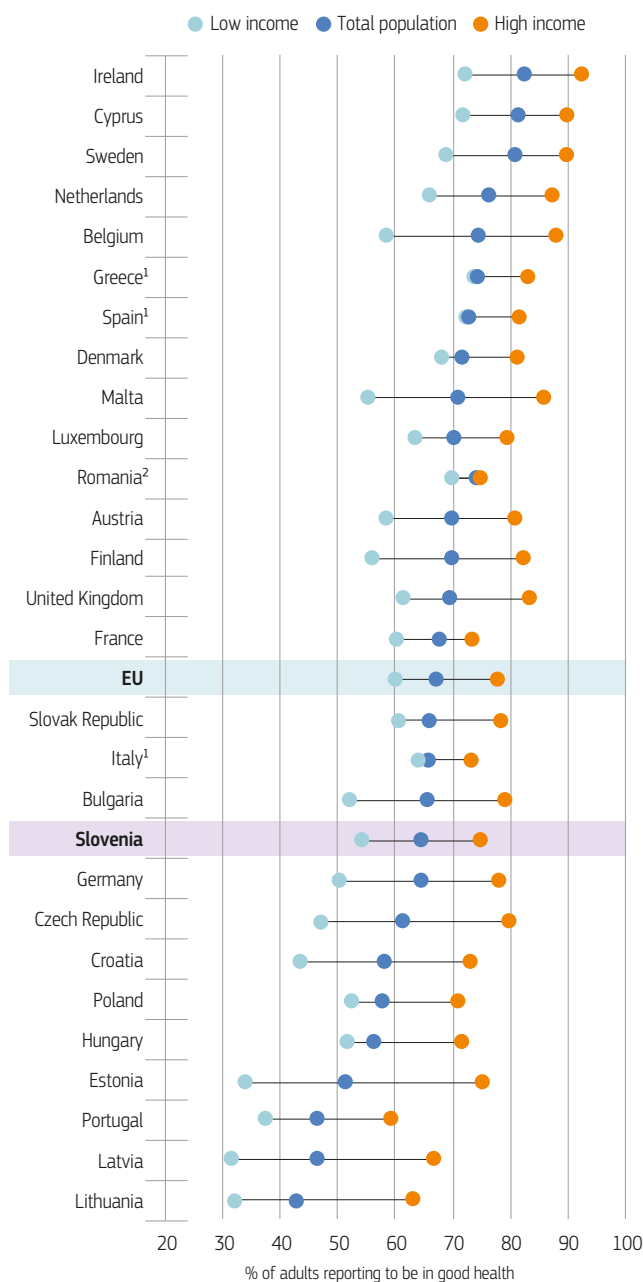
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

Two thirds of Slovenians consider themselves in good health, but the poorest feel well less often

About two thirds of the Slovenian population consider themselves to be in good health, which is on a par with the EU average (67%). But there is a noticeable difference across socioeconomic groups: while three quarters of the highest income quintile population regard themselves as in good health, just over half of those in the lowest income quintile feel the same (Figure 4).

Figure 4. There are large disparities by income group in self-reporting of good health



1. The shares for the total population and the low-income population are roughly the same.

2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

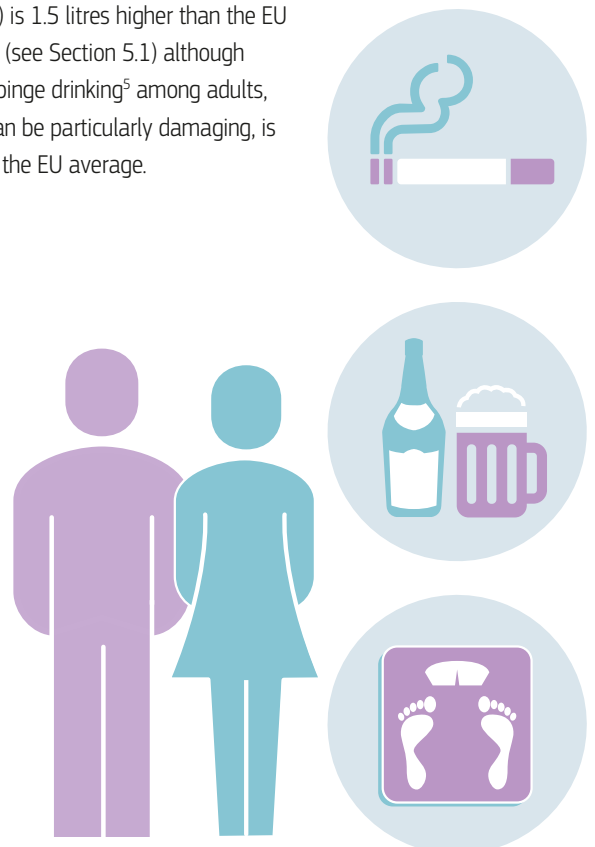
Behavioural risk factors have a considerable impact on health in Slovenia

The good health status of the population in Slovenia is linked to a number of health determinants, including living and working conditions, the physical environment in which people live, and a range of behavioural risk factors. Data from the Institute for Health Metrics and Evaluation suggest that nearly one third of the overall burden of disease in Slovenia in 2015 (in DALYs) is attributable to behavioural risk factors – including smoking, alcohol use, dietary risks and low physical activity.

Smoking has declined, but alcohol consumption remains high

Smoking rates among adults in Slovenia have declined since 2001 and are lower than in most other EU countries (19% vs 21% in 2014), with both men and women comparing well to their European peers. Smoking rates among both boys and girls have also fallen since 2001, bringing smoking rates for young people down to the EU average. However, further progress is desirable.

Recorded alcohol consumption per adult (11.5 litres in 2015) is 1.5 litres higher than the EU average (see Section 5.1) although regular binge drinking⁵ among adults, which can be particularly damaging, is close to the EU average.



There is a big gender gap in the proportion of Slovenian adults who report heavy episodic alcohol drinking, with nearly 30% among men compared to 10% among women. There are also worrying indicators on repeated drunkenness among 15-year-olds, which is roughly six percentage points higher than the EU average for both boys and girls (33% and 28%, respectively in 2014) (see also Figure 5).

High obesity rates and blood pressure levels reflect unhealthy diets

The obesity rate among adults in Slovenia is higher than in most other EU countries despite reporting above average levels of physical activity (Figure 5). Nearly one in five adults were obese in 2014, up from one in six in 2007. What is more, 20% of 15-year-olds were either overweight or obese in 2014, the fifth highest level in the EU, with boys particularly affected.

An important contributor seems to be the deteriorating diet of Slovenian adolescents in recent years. They appear to have some of the worst dietary behaviour in the EU with less than one in three eating fruit and vegetables regularly, more than one in three consuming sugar-sweetened beverages regularly and every second

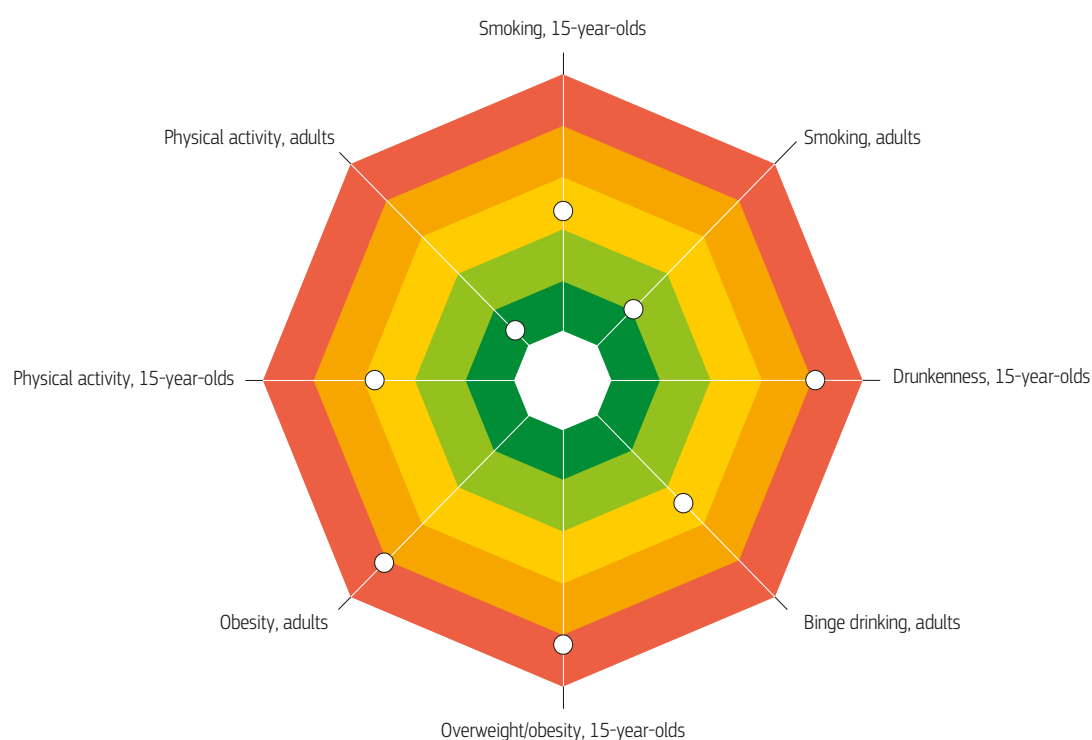
child skipping breakfast (Koprivnikar et al., 2013). Slovenians also have the second highest level of salt intake in the EU (Kloss et al., 2015), an important contributor to the fact that a quarter of the population had high blood pressure in 2014 (EHIS, 2015).

The Slovenian government has launched a number of policies and strategies to combat the rise in overweight and obesity and of hypertension with the aim of improving nutrition and physical activity for the whole population and from early life. The National Programme on Nutrition and Health Enhancing Physical Activity 2015–25 is a case in point.

Inequalities in risky behaviours are particularly large

As in other EU countries, behavioural risk factors are more common among population groups with lower income and lower levels of education. There is a pronounced gap of nearly five percentage points in daily smoking rates between adults with lower educational (16.4%) and higher educational (11%) attainment. Furthermore, the level of obesity in the population with lower education is more than two times that of the higher educated population – one of the largest disparities among EU countries.

Figure 5. Alcohol, overweight and obesity problems are greater than in most other EU countries



Note: The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

4 The health system

Reform attempts in the health sector have been contentious

Slovenia operates a compulsory Social Health Insurance system with a single payer, the independent Health Insurance Institute of Slovenia (HIIS). It provides near universal coverage (see Section 5.2). Governance and regulation are centralised within the Ministry of Health, which also owns all public hospitals and national institutes. Communities are responsible for the organisation of primary care, including capital investment in primary health centres and pharmacies.

The health sector has experienced delayed or failed reforms over the last few years. Health financing constitutes the most debated and difficult policy area, as evinced by a series of rejected proposals to abolish complementary health insurance (see Section 5.3). This difficulty in reaching consensus is a particular cause for concern because of the projected fiscal sustainability challenges that await Slovenia if there is no policy change. It is hoped that the adoption of the new National Health Plan (NHP) 2016–25 (Box 1) will help to resolve these blocks to reform.

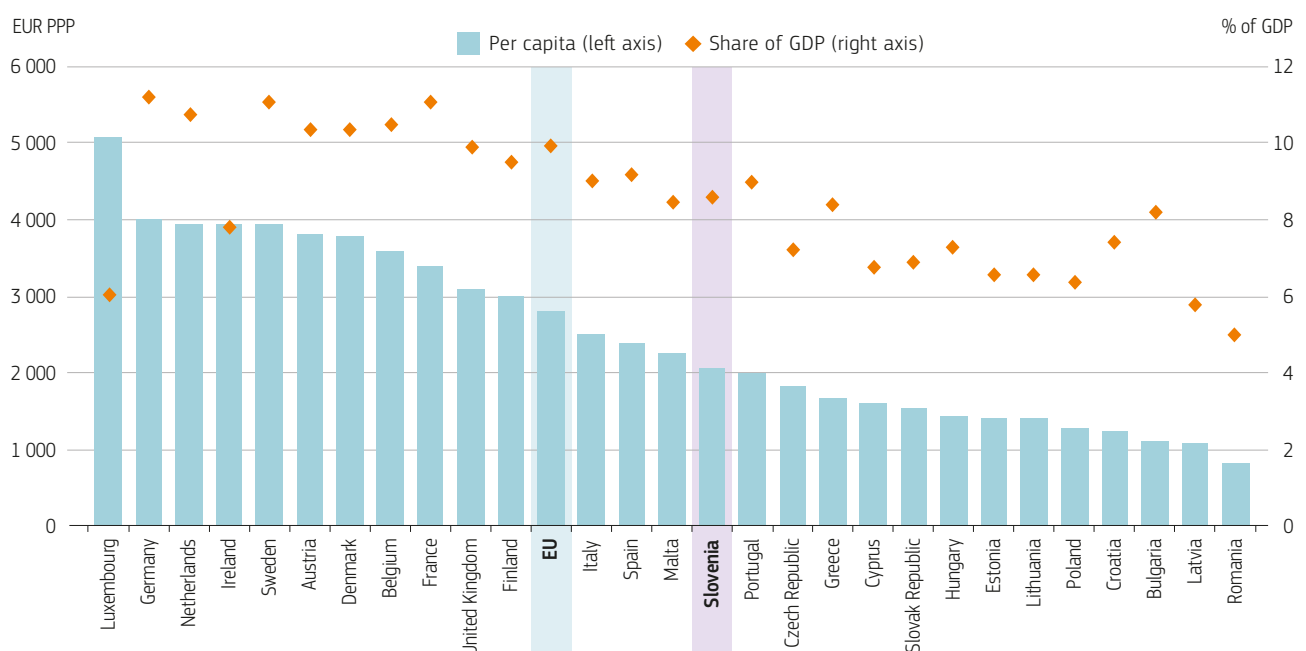
There is a high level of health spending but with a comparatively low public share

In 2015, Slovenia had the second highest per capita health spending among the newer Member States and the highest spending as a share of GDP (Figure 6). However, in response to the 2009 economic crisis, public spending on health has steadily decreased, driven down by cost containment measures such as salary freezes, reduction of tariffs and increased co-payments. In 2015, the share of public expenditure on health (71.1%) was seven percentage points below the EU average (78.7% in 2015).

The hospital payment system is only nominally based on diagnosis-related groups

Services provided in primary health care are covered through a combined system of capitation and fee-for-service payments. Outpatient (or ambulatory) specialist services in hospitals and outpatient clinics are paid on a fee-for-service basis, whereas inpatient care is covered (in theory) by fixed allocations and Diagnosis-Related Groups (DRG). However, in practice, hospitals are allocated budgets according to available resources and historical volumes and they usually continue to treat patients after having reached the nominal DRG-based budget cap (see Section 5.3).

Figure 6. Health spending is high compared to newer Member States but is below the EU average



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

Lack of doctors in primary care leads to over-referrals to specialists

Despite a steady increase in physicians, partly driven by migration from neighbouring countries, Slovenia has one of the lowest physician densities in the EU (see Figure 7). In 2014, the number of general practitioners and paediatricians still lagged behind most EU countries (Pavlic, Svab and Pribakovic, 2015), leading to problems of access and over-referrals to specialist care in some parts of the country (see Section 5.2). Nurse density was slightly above the EU average (Figure 7) in 2015.⁶ The NHP intends to improve workforce planning and to distribute health professionals across levels and sectors more effectively.

Although service organisation is fragmented, primary care does constitute a strong core

Primary care is provided in community-level health care centres and by private practices. Slovenia operates a typical gate-keeping system, in which patients need a referral for an outpatient (or ambulatory) specialist or hospital consultation. Although the primary care system is strong, particularly since 2011 when the government upgraded family medicine practices and increased the emphasis on prevention and care coordination, service organisation and delivery overall are highly fragmented (see Section 5.1).

Outpatient (or ambulatory) specialist care is provided by public hospitals, private outpatient specialist clinics and independent specialists that communicate insufficiently with the providers of primary and inpatient care, resulting in weak continuity and comprehensiveness of care (Kringos et al., 2013). The NHP includes plans to improve coordination and integration specifically with a view to reducing the burden on secondary care.

Slovenia is one of the fastest ageing EU Member States, so demand for long-term care is growing. It is provided mainly in institutional settings with little emphasis on community or home care. There is no properly integrated long-term care system coordinating between providers and this is reflected in fragmented service provision and disjointed governance (Normand, 2017). The current work on a Long-Term Care Act aims to address these challenges (see Box 1).

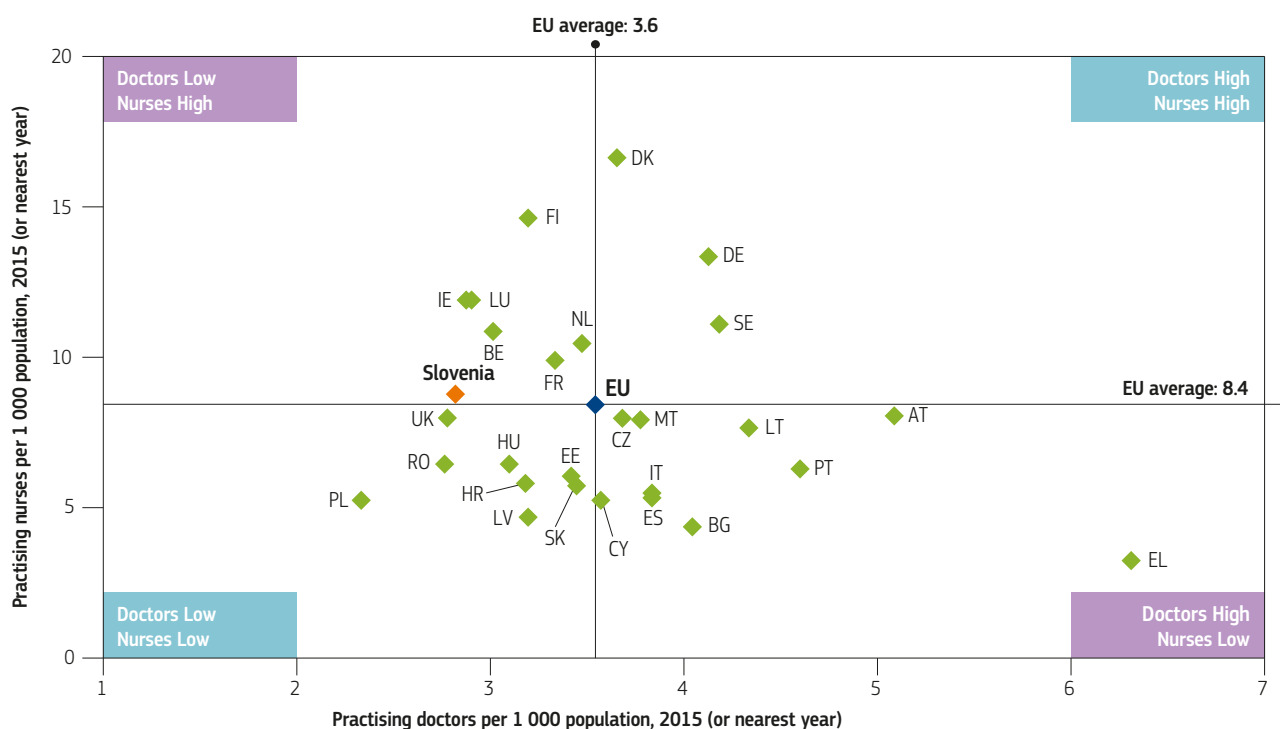
BOX 1. PLANNED STRUCTURAL REFORMS IN LONG-TERM AND PRIMARY CARE WILL TACKLE FISCAL SUSTAINABILITY

Slovenia has urgently needed health care sector reforms for some time. In March 2016, the government adopted the National Health Plan 2016–25 and launched a number of legislative initiatives to address and reform the most pressing issues with a view to ensuring fiscal sustainability. The NHP seeks to strengthen primary care and provide greater access to comprehensive and quality treatment through better care integration and a more adequate professional skill-mix across care levels. These reforms should also help Slovenia to respond to the changing needs of an ageing population. So far, progress is slow with the Act on Long-Term Care and a new National Health and Health Insurance Act (see Box 2, section 5.2) still pending due to political opposition and debate over legal specifications and the transfer of responsibilities.



6. However, the Slovenian figure includes health technicians, who are not nurses according to the Professional Qualifications Directive, thereby overestimating the number of nurses compared to other countries.

Figure 7. Low physician density undermines the strong primary care system



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

5 Performance of the health system

5.1 EFFECTIVENESS

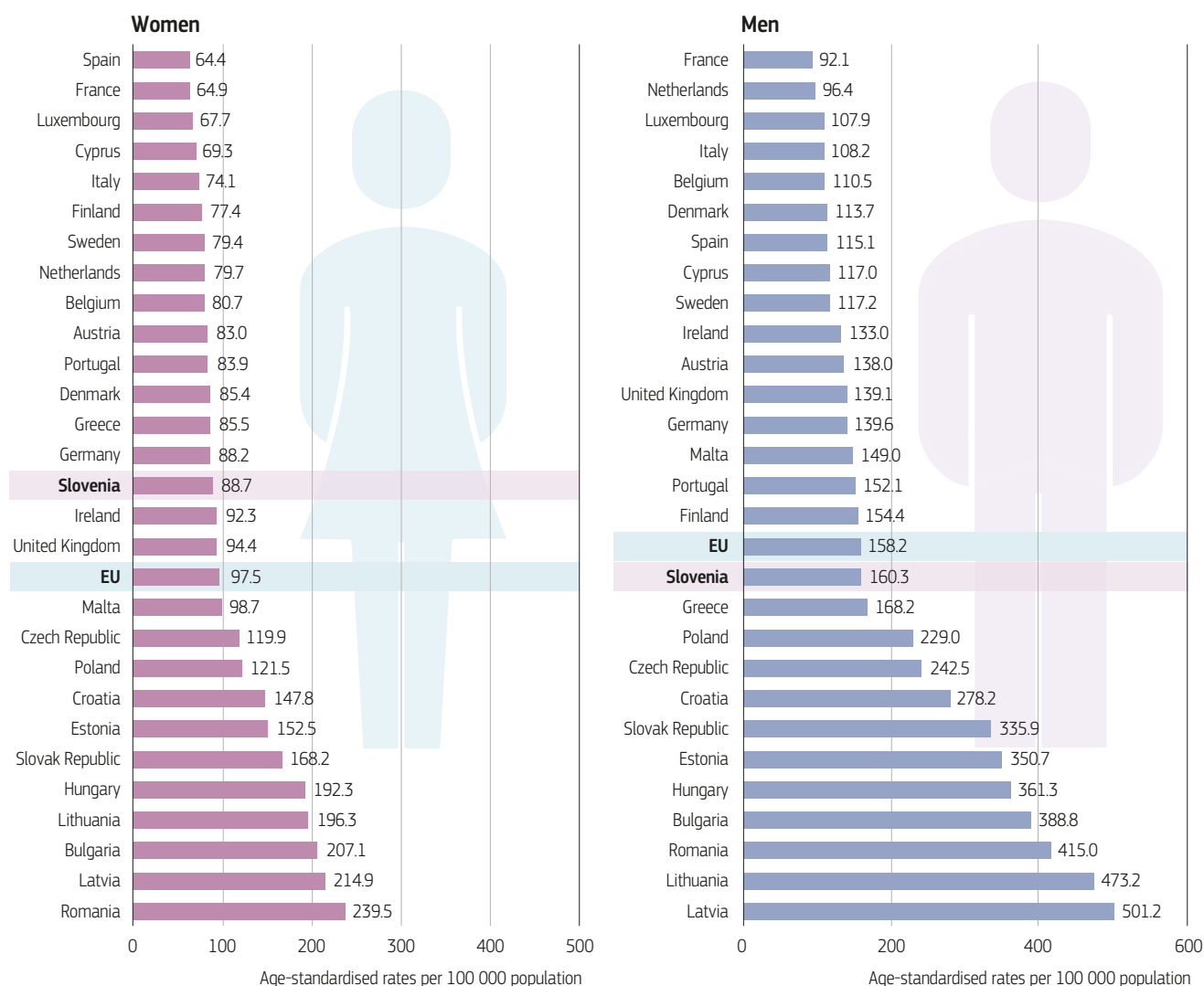
Slovenian men are lagging behind women in amenable mortality

The health system has made important contributions to the health status of Slovenia's population. The country is, together with Malta and Cyprus, the best performing newer Member State in terms of amenable mortality (Figure 8).⁷ About 12% of deaths are considered amenable to care, slightly above the EU average (11%). Most gains can be attributed to the steadily decreasing death rates from cardiovascular diseases and several types of cancer.

Cervical cancer and stroke treatment could be improved

The effectiveness of cancer prevention and treatment in Slovenia has improved markedly, despite the rise of some cancers in the mortality rankings due to rising numbers of new cases (see Section 2). For example, CONCORD programme data show that the 5-year survival rate of women with breast cancer has reached 83.5% for the period 2010–14 and is now in the top third of EU countries. Colorectal cancer survival rates have also risen and are now better than many other countries with available data. Screening programmes for both cancers were introduced in 2008, with average or above average population coverage for countries with available data.

7. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Figure 8. Slovenia reports comparatively low amenable mortality particularly for women

Source: Eurostat Database (data refer to 2014).

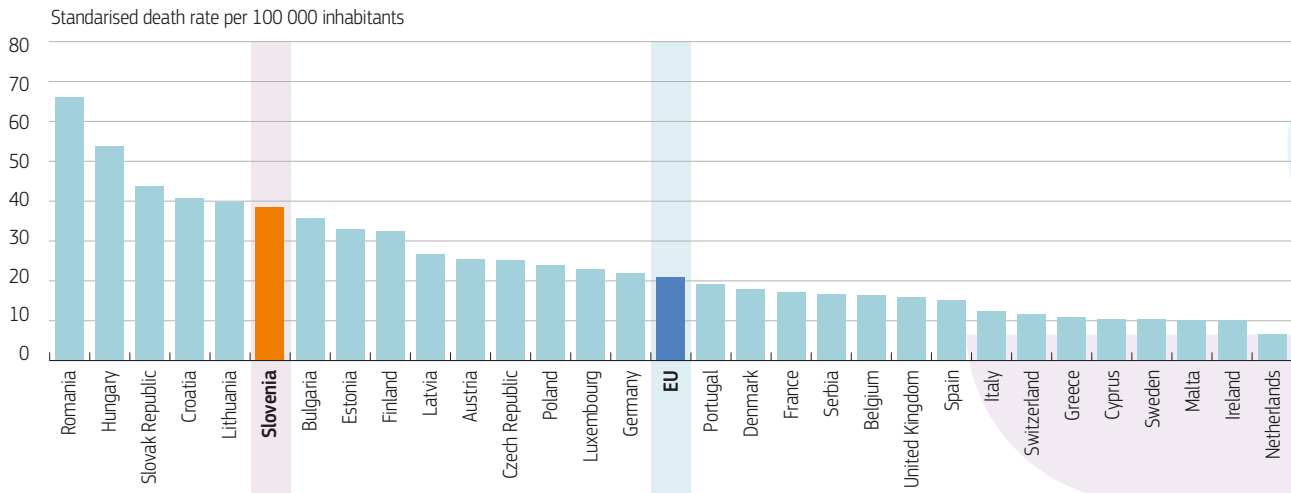
Yet even with a comprehensive screening programme in place, good outcomes are not guaranteed. This is exemplified by the cervical cancer programme. CONCORD programme data show a modest decrease in 5-year survival rates between 2005–09 and 2010–14, reaching 65.5%, below high-achieving countries like Denmark (69.5%) and Sweden (68.3%).

Preventable deaths from alcohol abuse remain high and signal the need for a coherent response

The level of alcohol consumption among Slovenians is high, especially among men and young adults (see Section 3). As a result, and despite a decline over the past decade, Slovenia still performs

comparatively badly in preventable deaths related to alcohol misuse. In particular mortality from chronic liver disease in men is among the highest in Europe (Figure 9). Furthermore, large regional differences exist in alcohol consumption and related death rates. The risk of alcohol-related death is nearly three times higher in eastern than in western Slovenia (NIPH, 2016).

Measures are in place to limit the harmful use of alcohol, including a ban on selling alcohol to those under the age of 18, as well as a high excise duty on beer (one of the highest in the EU) and pure alcohol. However, there is no excise duty on wine (the most commonly consumed alcohol) and the allowed quantities of homemade alcohol were raised in 2016. Overall, there is room to further consider excise taxes and incentives.

Figure 9. Deaths related to chronic liver disease among men are high in Slovenia

Source: Eurostat Database (data refer to 2014).

Prevention policies on drunk driving have been particularly helpful

In 2010 more than one third of road traffic deaths involved alcohol, one of the highest shares in Europe. Stricter sanctions for drunk driving were introduced, accompanied by counselling and rehabilitation measures (2010), resulting in a significant decrease in traffic accidents involving alcohol (Blažko, 2016; NIPH, 2016). This has contributed to the fall in death rates related to external causes, although these remained above the EU average in 2014.

Strong action on tobacco control has increased

Legislation restricting smoking in closed public spaces came into force in 2007. Since then, lung cancer mortality has decreased – although this probably partly reflects a decline in smoking prevalence that started even before these prevention measures. The 2014 reform on family medicine practices may also have long-term benefits as it strengthened prevention activities, with designated nurses responsible for screening, counselling and follow up of patients involved in smoking cessation programmes.

Most importantly, new legislation on tobacco control adopted in February 2017 has introduced strong health warnings on packaging (also, from 2020, plain packaging will be mandatory), a total ban on advertising and the promotion of all tobacco products, and a ban on smoking in all vehicles in the presence of minors. The same restrictions apply to e-cigarettes, herbal smoking products and novel tobacco merchandise.

Immunisation rates for measles in infants and influenza in the elderly are worrisome

There are extensive compulsory vaccination programmes for children and adolescents, which seem to be successful. Immunisation levels in infants are high for diphtheria, tetanus and pertussis, and for *Haemophilus influenzae* type B (95% in 2014–15). However, while the measles immunisation rate was 93% of infants at first dose, only 89% received the second dose (2016). Also worrisome is vaccination coverage for influenza among people over 65. It has continuously fallen over the last decade, from 35% of the population in 2005 to 10% in 2015, moving Slovenia far below neighbouring countries and away from the target of 75% coverage set by both the World Health Organization and a 2009 EU Council Recommendation.

Implementation of quality management systems has not matched expectations

Although most hospitals are accredited by international accreditation organisations, implementation of other recommendations under the National Strategy for Health Quality (2010–15) has lagged behind plans. In particular, systems for internal monitoring of patient safety, quality of care and uptake of evidence-based clinical guidelines were not set up in a uniform and structured manner (Quentin et al., 2015). In 2011, a broad set of quality indicators was set out with the expectation that hospitals would monitor and publish their performance. However, data limitations and the lack of external verification have impeded the reliability of the approach. Similarly, safety indicators (patients' falls and methicillin-resistant *Staphylococcus aureus* infection rates) are not reliable. Current efforts to establish an Agency for Health Quality and Safety as part of the NHP may help to overcome these challenges and improve quality assurance.

Looking at some indicators on the quality of acute care, Slovenia records relatively low levels of 30-day mortality after admission to hospital for acute myocardial infarction. However, 30-day mortality for stroke (12.1 deaths per 100 patients in 2015) was one of the worst among countries with data available and almost two times greater than in neighbouring Italy and Austria, although this rate has come down over the past few years. There are also concerns that the wide range of specialised services offered by relatively small regional hospitals may undermine care quality, patient safety and efficiency simply because providers will tend to perform only a few procedures of a specific type per year.

Effective primary care manages to rein in avoidable admissions

Slovenia has relatively low numbers of avoidable hospital admissions, suggesting that despite the need for better coordination primary care is effective. Indeed, admissions for asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure and diabetes were all below the average for EU countries with data available (although the first two, may be partly attributable to declining smoking rates) (Figure 10).

The upgrading of family medicine practices in 2011 was an important government initiative to improve care coordination and the management of chronic diseases. These 'model practices' include a designated nurse with (part time) responsibility for screening for chronic disease risk factors, preventive counselling and care coordination. By 2014, about half of all primary care provision was in such 'model practices' and a nationwide roll-out will be completed by 2017. This should help achieve NHP commitments to overcome the fragmentation of service organisation and to strengthen coordination between providers across different care levels

5.2 ACCESSIBILITY

Slovenia reports very low levels of unmet needs for medical care

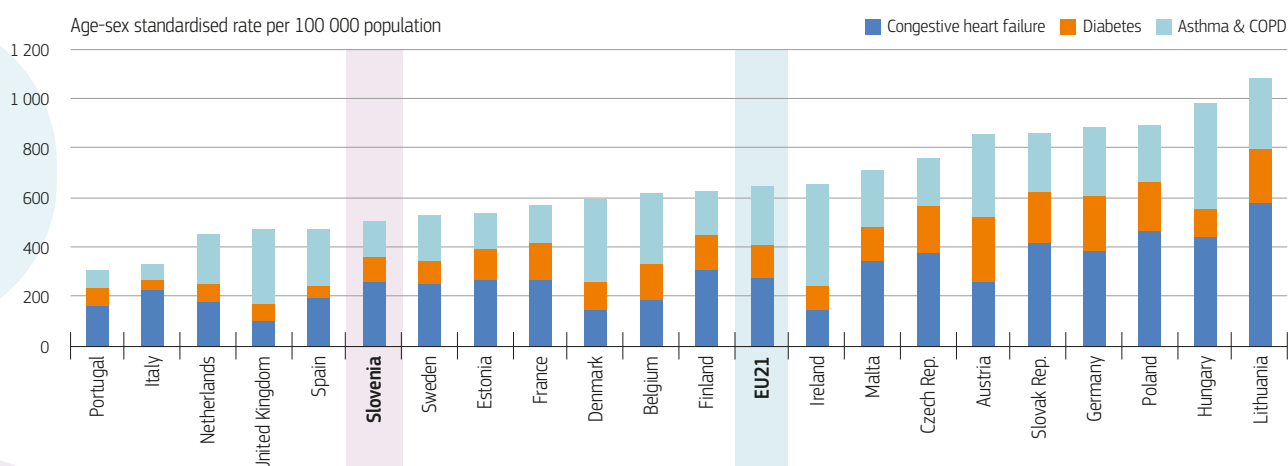
All permanent residents are entitled to the benefits covered by the compulsory health insurance system and coverage is nearly universal. Less than 1% of the population is not covered, and these are mainly people whose residence status is unclear ('commuters' but also homeless people, irregular migrants and asylum seekers). People without compulsory health insurance are nonetheless entitled to emergency medical services.

Slovenia has had one of the lowest levels of unmet need for medical care in the EU for more than a decade, and preserved this even during the economic crisis. It also seems to have very small variation in unmet need by income groups (Figure 11). However, these figures have to be analysed with caution because the Slovenian survey applied questions on unmet needs in an ambiguous way (European Parliament, 2016), and because there is some question as to whether unmet need for secondary care is masked by the effective gate-keeping system.

The benefit package is broad and could be more explicitly defined

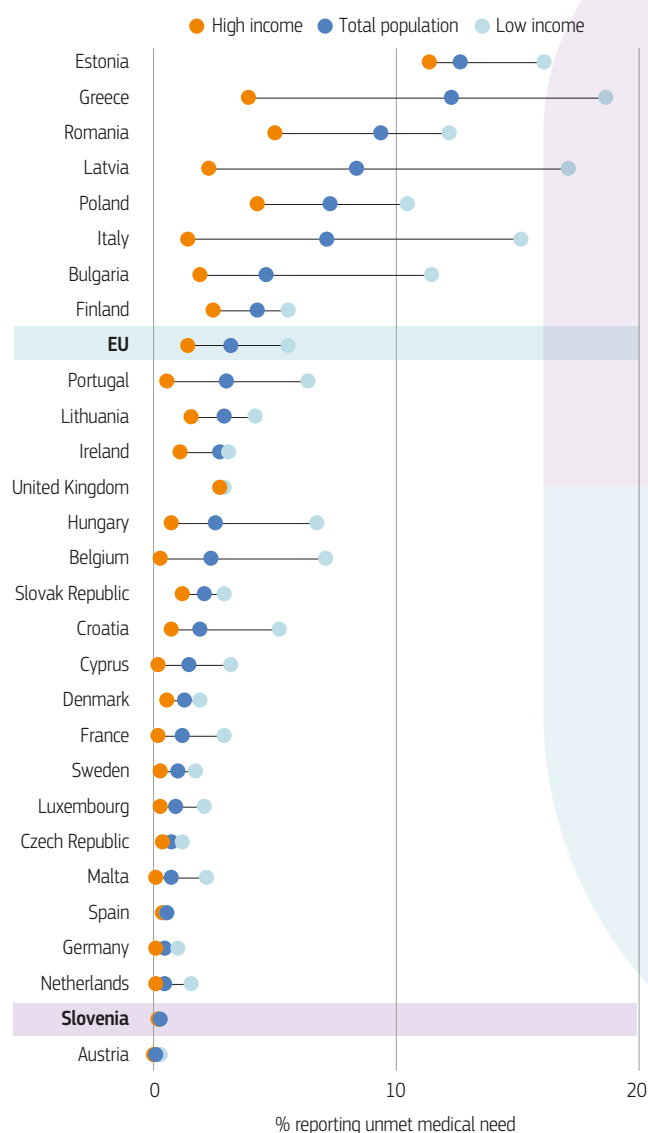
The insured population enjoys a broad range of benefits. Compulsory health insurance does not define a comprehensive list of all benefits, nor does it explicitly exclude services from public coverage. Instead, the Health Care and Health Insurance Act mandates the HHS to determine co-payment levels for a number of services. However, there is scope for eliminating medically unnecessary or ineffective services from the benefit baskets, which could be achieved by more effective health technology assessment (see Section 5.3).

Figure 10. Slovenia has low avoidable hospitalisation rates for ambulatory care sensitive conditions



Note: Rates are not adjusted by health care needs or health risk factors. **Source:** OECD Health Statistics (data refer to 2015 or latest year).

Figure 11. Unmet need for medical care is the second lowest in the EU



Note: The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

The majority of Slovenians rely on complementary voluntary health insurance to cover co-payments

Co-payments apply to most types of health services and vary between 10% and 90%, depending on the type of service. For example the minimum share of costs covered is 90% for urgent interventions and intensive therapy; 80% for specialist surgery, orthodontics and other aids; and 70% for pharmaceuticals on the 'positive list' covered by the HHS. Children and students up to the age of 26 as well as vulnerable groups are exempted from all co-payments.

Because co-payments are uncapped and required for even basic services they can accumulate quickly. Therefore, 87% of the population purchases complementary Voluntary Health Insurance (VHI) (in 2015). The premiums for complementary VHI are community rated with a 'flat rate' for all. People can also purchase VHI policies that offer a wider scope and higher standards of benefits. For low-income groups that cannot afford complementary health insurance, there are special mechanisms to cover co-payments from the state budget.

In the economic crisis complementary voluntary health insurance protected against over-expenditure

In the context of fiscal consolidation measures in the aftermath of the economic crisis, co-payment levels were gradually increased. In effect, the cost of coverage for certain services was moved from compulsory health insurance to VHI, keeping public expenditure sustainable. The extensive VHI coverage made it possible for the government to take these steps and largely kept households protected from incurring catastrophic co-payments.⁸ It did, however, necessitate an upwards adjustment of VHI premiums, which happened in 2012, shifting costs from public (compulsory insurance) to private (VHI) spending (see Section 5.3).

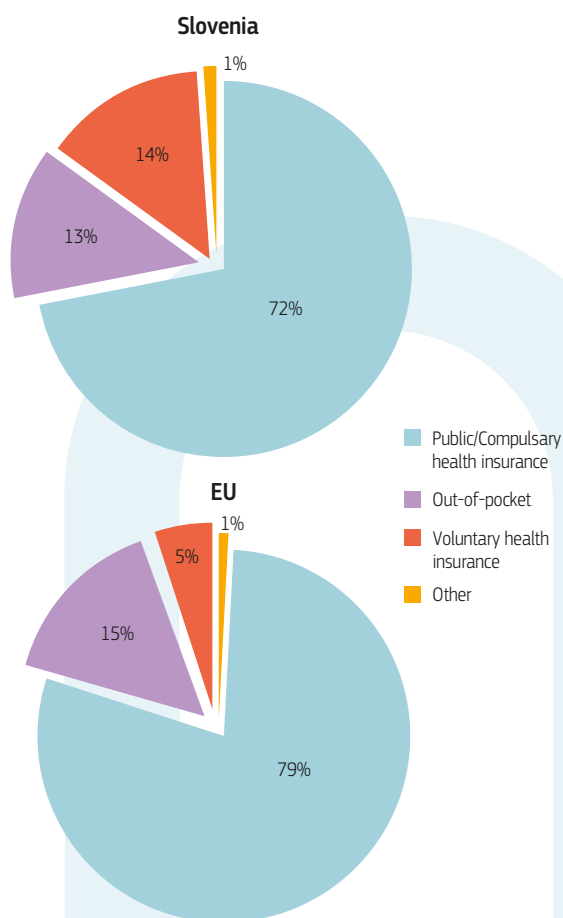
As a result, overall private spending as a share of total health spending increased from 26% in 2008 to 28% in 2015. Nevertheless, out-of-pocket spending is below the EU average (Figure 12). It has remained stable throughout the last decade and during the economic crisis. Although there are questions about the high administrative cost of the VHI scheme, it seems to explain the very low proportion of people reporting unmet medical need for financial reasons. These low levels also apply to the lowest income quintile, where reported unmet need stood at 0.1% compared to 4.1% in the EU (2015).

Long waiting lists and geographic disparities affect access

The availability of health care services is generally good. However, waiting lists represent a challenge, although they seem not to have translated into an elevated unmet need due to waiting. The share of people reporting waiting times increased from 6% in 2007 to 13% in 2015, in particular for outpatient (or ambulatory) specialist services. This is probably the effect of fiscal consolidation measures during the crisis, lack of doctors and over-referring by primary care physicians (Pavlic, Svab and Pribakovic, 2015).

Challenges in access also exist in terms of geographic distribution of primary care physicians. This has been partly addressed with the increase of publicly financed residency places in family medicine and the development of the 'health care network'. The network concept

Figure 12. Slovenia has the highest spending on voluntary health insurance in the EU



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

is that setting specific targets, such as the expected number of patients per general practitioner or primary care paediatrician, will help to determine where more resources are needed. There is scope to rationalise secondary care but past proposals on the closure or re-profiling of hospitals met strong public opposition from local communities, impeding progress.

The national eHealth project is in part an attempt to reduce waiting times (although it also seeks to increase transparency) and includes e-appointments, e-waiting lists and e-referrals. In addition, the government recently launched an initiative to analyse waiting times and to pilot innovative approaches to reducing them. A project launched in 2017 will give extra payments to public facilities to increase their care volume provided they reduce waiting times and improve quality of care.

5.3 RESILIENCE⁸

Long-term stability of health care funding is low, but plans exist to broaden the revenue base

The exclusive reliance on health insurance contributions makes health sector revenues very susceptible to labour market fluctuations. The key challenge is to diversify the resource base with more reliable funding and to reduce the pro-cyclicality of health care expenditure. In fact, this is one of the goals of a new reform, which is still under preparation (Box 2).

Problems with the financing system were felt especially strongly during the crisis when job losses and slower wage growth led to reductions in HIIIS contributions. Actual volume of services and goods paid for by the HIIIS were maintained during the crisis but this was only made possible by reducing reimbursement levels for medical care; delaying provider reimbursements; and shifting costs from (public) compulsory insurance to (private) complementary VHI (Cylus, 2015) (see Section 5.2). Because expenditure reductions more than offset the reductions in revenues, the HIIIS was back in surplus by 2014.

For Slovenia, sustaining current and future expenditure levels remains particularly challenging, as health and long-term care expenditure are expected to grow faster than in much of the EU (European Commission and Economic Policy Committee, 2015). This is due to a rapidly ageing population, with associated higher levels of (multiple) chronic diseases, as well as demand for expensive new medical technologies.

BOX 2. MEASURES TO ENSURE FISCAL SUSTAINABILITY ARE HIGH ON THE POLITICAL AGENDA

The proposed Health Care and Health Insurance Act addresses the challenges of the long-term stability of health system funding through measures that seek to diversify funding sources. In particular, the bill proposes an extended contribution base for compulsory health insurance that takes direct and indirect income into account and unifies contribution rates across insured populations. Additional funding from general taxation would finance specific programmes (traineeships, medical specialisations and tertiary education). The bill also envisages the abolition of the complementary VHI scheme by 2019, and its replacement with an income-dependent contribution that will be more efficient to administer.

8. Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

Despite bed closures low bed occupancy rates may still signal some overcapacity

The number of acute hospital beds and the average length of stay have decreased since the early 2000s (Figure 13). This reflects a number of factors: the shift from bed-day payments to case-based (DRG) payments; tariff reductions and rationalisation during the crisis; and the rise of day care (from 11.1% of all hospital cases in 2005 to 30% in 2013). As a result, the number of beds is now around the EU average while the average length of stay is well below average 6.8 days compared to 8 days (2015).

However, bed occupancy rates are well below the EU average, suggesting overcapacity. This, together with the fact that there are still many smaller regional hospitals, suggests that there is room to rationalise the hospital network to improve efficiency; notwithstanding the public opposition this is likely to prompt (see Section 5.2).

More people could be treated in day care settings

Since 2010, financial incentives have been in place to encourage the substitution of day or ambulatory (or outpatient) treatments for inpatient care. Cataract surgery has been a particular success with one of the highest percentages of ambulatory cases in the EU (2015). Tonsillectomies, in contrast, are still exclusively performed in inpatient settings (Figure 14). Hospital budgets owe more to historical precedent (through caps) than to effective purchasing and hospital deficits are ultimately borne by the government. There are therefore

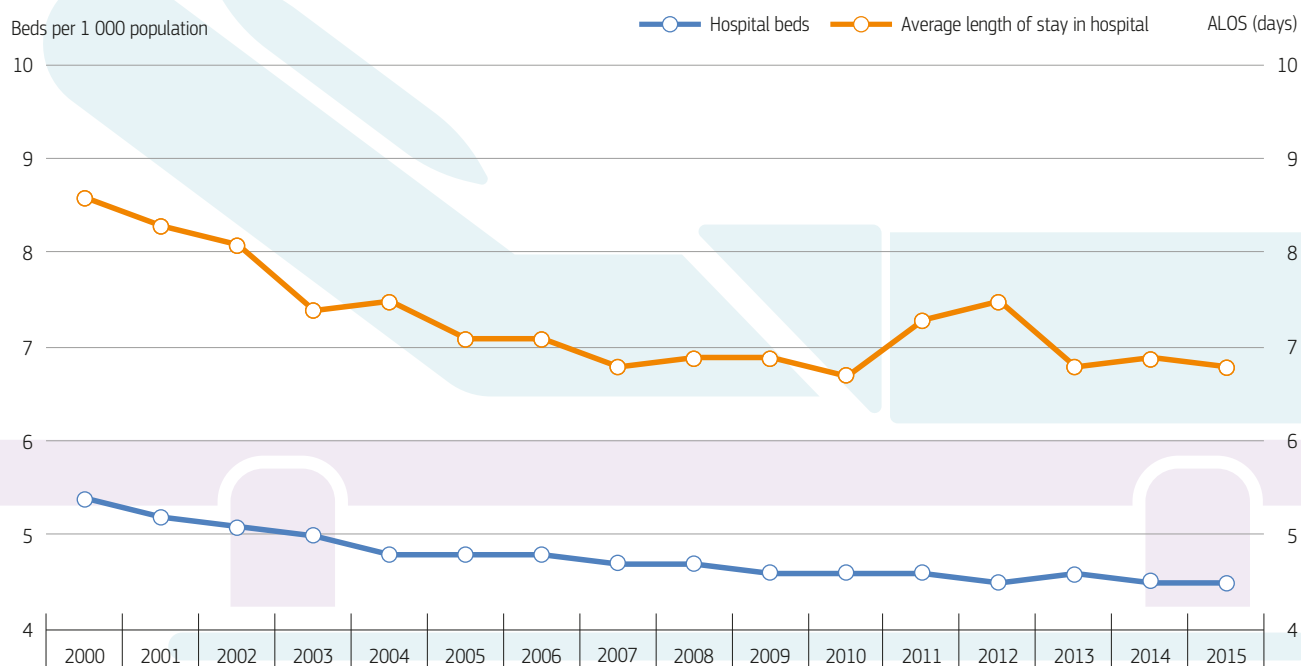
few incentives to make more efficient use of hospital resources. Improving the current DRG model to reflect actual costs would be one way to create greater financial incentives for increased efficiency. In response, a working group has been set up to undertake a nationwide cost analysis of hospitals' activities in order to eventually replace the faulty DRG system currently used in the financing of hospital and specialist ambulatory activities (see Section 4).

A new joint public procurement system is in place but health technology assessment is still lacking

The Ministry of Health has recently developed a new public procurement system to address this source of waste. Mandatory centralised procurement of medicinal products and the most commonly used medical devices in all public hospitals has now been implemented. A central register of medicinal products, their characteristics and prices was set up in 2017 aiming at more efficient allocation of resources and to enhance transparency.

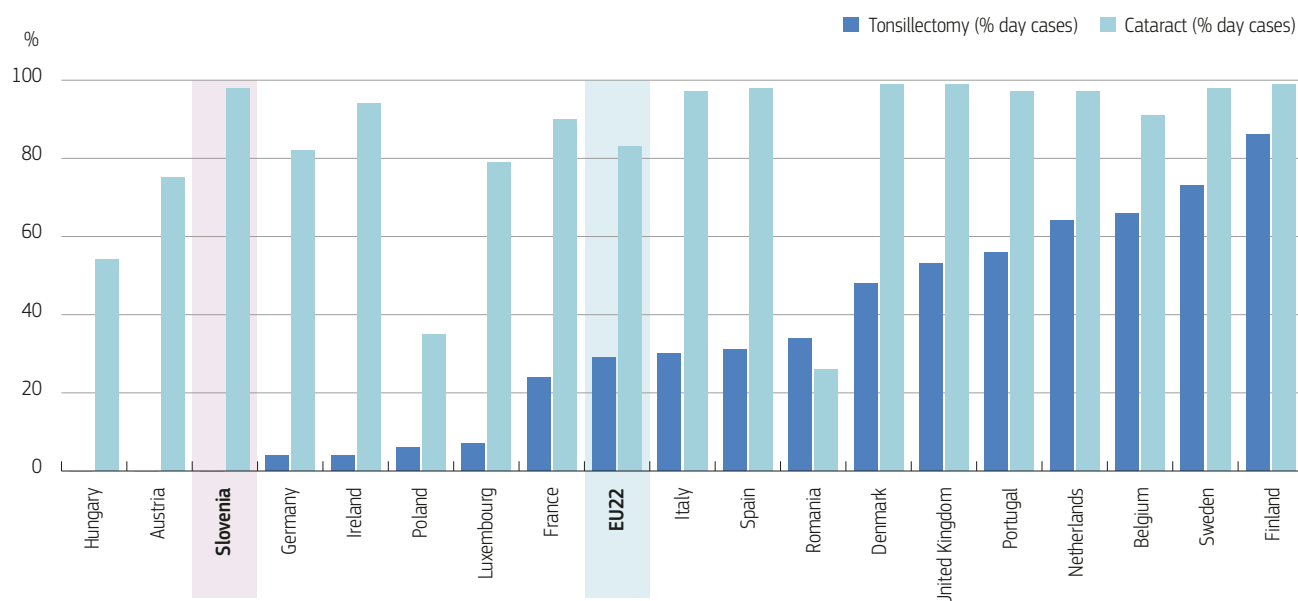
Health technology assessment would clearly also be an asset in terms of efficient allocation of resources and could help to determine which (particularly new) benefits should be covered by the HHS. Some agencies and the HHS use certain health technology assessment mechanisms during regular assessments but the NHP mandates its wider use. The draft government Act on Health Care Quality and Safety envisages the creation of a health technology assessment agency.

Figure 13. Average length of stay and bed numbers have fallen since 2000



Note: There is a break in the ALOS series in 2011 and 2013.

Source: Eurostat Database.

Figure 14. Slovenia shows mixed success in substituting inpatient care with day surgery

Source: Eurostat (data refer to 2015).

The shortage of doctors highlights the scope for task shifting

The shortage of medical doctors is well recognised but persists even though a second medical faculty was opened in Maribor (in 2003) and provision has been made for more foreign doctors to practice in Slovenia. Given the difficulties in addressing shortages and also that specialists outnumber family medicine doctors (despite the importance of primary care) there may be a need for task substitution. The NHP suggests enhancing the scope of practice for community nurses to optimise patient-centred care.

There is progress on eHealth infrastructure but delays in some national roll-outs

Slovenia has made substantial efforts to strengthen its health information infrastructure through its national e-health project. The e-prescription system is widely used by all providers and has improved interoperability and transparency. The e-registry of patient data and patient summaries is being implemented, as is the registry of health care providers, making for easier exchange of information between providers. Other e-health initiatives are being rolled out, such as an e-referral system, which is soon expected to completely replace paper referrals; the e-booking system, which started in late 2016; and the zVem patient portal (enabling patients to see their own medical data) which launched in January 2017.

There are strong commitments to better governance, accountability and communication

The NHP recognises the need to protect the public interest, decrease corruption and improve both the oversight of public-private partnerships and the governance of health care institutions. The Ministry is taking steps to address both transparency and accountability. However, the relationships between existing supervisory institutions (Ministry of Health, Court of Audit, HIIS, Medical Chamber) and their respective responsibilities are not sufficiently clear.

Crucially, the implementation of long-awaited reforms is still pending

In light of the political stalemate (Box 1), the Ministry of Health commissioned a wide-ranging health system review in 2015 to support and inform the development of the new NHP. The NHP addresses the shortcomings of the health system as a whole, was opened up to extensive public consultation and was adopted by Parliament in March 2016. It includes specific efficiency indicators and criteria to allow measurement of how far it has met its objectives. The NHP is central to the longer-term future of the health system. It addresses fiscal sustainability both through the proposed Health Care and Health Insurance Act (which will be crucial in making the system financially stable) and in the outstanding reform of long-term care (which tackles the needs of the ageing population within existing budgetary constraints). However, neither policy is agreed yet and much depends on their final adoption by the government.

6 Key findings

- Slovenia has made great progress in closing the gap with the EU in terms of health status. Its life expectancy gains (of nearly five years between 2000 and 2015) are the third largest increase in the EU, and self-reported health is now close to the EU average. Yet life expectancy at birth for Slovenian men is six years less than for women and nearly seven years higher for men with a university education than those with lower secondary education.
- Smoking levels have declined, but the level of alcohol consumption among Slovenians is high, especially among men and young adults. Obesity levels among adults and 15-year-olds are above the EU average and have worsened. Moreover, many behavioural risk factors are much more prevalent among population groups disadvantaged by income and education. There are also comparatively higher than average suicide rates, especially for men.
- The Slovenian health system provides near universal coverage but there are extensive co-payments. To cover these, 87% of the population have voluntary health insurance and there is help for those who cannot afford it. Out-of-pocket payments are low overall, but the share of private expenditure is high compared to the EU average.
- The health system has made good progress in effectiveness and quality as reflected in low amenable mortality rates. However, despite the strong primary care system, there is a lack of coordination and integration across levels and sectors, causing discontinuity of care. Furthermore, although hospitals are generally performing well, the high 30-day fatality for stroke is alarming, as is the slight reduction in 5-year survival rate from cervical cancer.
- Slovenia has a good record in terms of unmet medical needs, although the data are not entirely reliable. There are very few financial barriers to access and although distribution of physicians is uneven, geographic barriers are also low. Slovenia has started to address geographical disparities in part by building on its successful initiative on primary care. It is rolling out the upgraded family medicine 'model practices' nationwide and has also increased medical training capacity, both to improve access to care in underserved areas and as a more efficient way of meeting need.
- The Slovenian health system is comparatively efficient, although there are some fiscal sustainability concerns. Increasing the use of day care, further rationalising the hospital sector (and the oversupply of small regional hospitals), as well as improving the payment and procurements systems could all boost efficiency further.
- There is a longstanding need to redesign the composition of health financing to ensure fiscal sustainability. After years of delays and abandoned reform efforts, the government has made tangible progress with a new National Health Plan that sets out future directions. The new Health Care and Health Insurance bill seeks to broaden the revenue base and ensure more stable financing. It is unclear whether proposals on long-term care will be supported, which aim to develop an affordable, effective and sustainable response to the needs of a rapidly ageing population.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

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Please cite this publication as:

OECD/European Observatory on Health Systems and Policies (2017), *Slovenia: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.
<http://dx.doi.org/10.1787/9789264283558-en>

ISBN 9789264283558 (PDF)

Series: State of Health in the EU
ISSN 25227041 (online)